MEPS Insurance Component
Glossary of Health Insurance Terms

Terms used in the MEPS-IC questionnaires are listed first in order of their appearance on the main questionnaires (MEPS-10 and MEPS 10s). Additional terms used in the MEPS-IC tables follow in the second section. In the last section, additional relevant health insurance terms are defined.

I. Terms That Appear in the MEPS-IC Questionnaires

Active employee: A person who is employed full- or part-time regardless of whether the employee is considered permanent, temporary, or seasonal. Includes owners and officers of the organization. For the MEPS-IC survey, this excludes individuals who were contract laborers, retirees, laid off, left employment prior to the survey reference year or who were hired after the survey reference year.

Health insurance plan: An insurance contract that provides hospital and/or physician coverage to an employee or retiree for an agreed-upon fee for a defined benefit period, usually a year.

Offer health insurance: To make available or contribute to the cost of any health insurance plan for current employees and/or retirees.

Single service plans (optional coverage plans): Separate coverage for a limited area of medical care to supplement the basic health insurance plan. These plans are often offered through an insurance company/carrier separate from the one providing basic health coverage. An additional premium is paid by the enrollee and/or employer for this optional coverage. (Example: Dental or Vision Plan)

Typical pay period: Any pay period during the prior calendar year in which employment was neither unusually high nor unusually low. MEPS-IC respondents are asked to provide data for a typical pay period; not for a specific date and not for the entire year.

Eligible employee: An employee that is eligible to enroll in a health insurance plan offered by the employer if he/she so desires. An employee that is eligible to enroll during the plan enrollment period is considered eligible even if the employer is surveyed at other times of the year.

Enrollee: An employee that is enrolled in a health insurance plan offered by the employer. Enrollees do NOT include any dependents covered by the plan.

Full-time employee: In generally, a full-time employee works 35 to 40 hours per week. For the MEPS-IC survey, the definition of a full-time employee is that defined by the respondent—no specific minimum number of hours is specified in the questionnaires.

Part-time employee: An employee not defined by the respondent as being full-time. Excludes temporary or seasonal employees.

Employee pre-tax contributions to health insurance: Also known as a Premium only plan (POP), this is the most basic type of Section 125 Plan. An employee can pay his/her share of the premium for employer-sponsored health insurance through a payroll deduction,

prior to taxes being withheld. This lowers the amount of income on which the employee must pay taxes.

Flexible spending accounts or arrangements (FSA): Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money, though an IRS ruling in 2005 allowed employers to grant a 2½ month extension. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Flexible benefits plan (cafeteria plan) (IRS 125 Plan): A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage. (The MEPS-IC stopped collection of information on Cafeteria Plans in 2003.)

Long-term care insurance: Covers all forms of health care (both institutional and noninstitutional) required by the chronically ill or disabled. This is often provided as optional coverage.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986): Part of this law requires employers to continue offering health coverage for enrollees and their dependents for a period of time after an enrollee leaves the firm. This is commonly referred to as COBRA coverage. Typically, the enrollee pays the entire monthly premium when covered by COBRA: an administration fee of up to 3 percent may also be applicable.

State continuation-of-benefits laws: Laws which vary by state mandating that organizations provide enrollees with the option of continuing to purchase insurance through the organization for a limited amount of time after they leave the organization's employ.

Types of health care provider arrangements

- Exclusive providers: Enrollees and covered dependents must go to providers associated with the plan for all non-emergency care in order for the costs to be covered. Most health maintenance organizations (HMOs), individual practice associations (IPAs), and exclusive provider organizations (EPOs) are exclusive-provider plans.
- Any providers: Enrollees and covered dependents may go to providers of their choice with no cost incentives to use a particular subset of providers. Most conventional-indemnity plans are any-provider plans.
- Mixture of preferred and any providers: Enrollees and covered dependents may go to any provider but there is a cost incentive to use a particular subset of providers. Most preferred provider organizations (PPOs) and point-of-service (POS) plans are mixed-provider plans.

Gatekeeper: Under some health insurance arrangements, a gatekeeper is responsible for the administration of the patient's treatment; the gatekeeper coordinates and authorizes all

medical services, laboratory studies, specialty referrals and hospitalizations. Gatekeepers are more often associated with managed care plans. A gatekeeper may or may not be a physician.

Primary care physician (PCP): A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals.

Health reimbursement arrangement (HRA): An arrangement where the employer agrees to reimburse health expenses up to a set amount per year for an employee. While often associated with a high deductible health plan, this is not a requirement. Only the employer can fund a HRA. Unused funds can be carried over to the following year.

Health savings account (HSA): A trust account owned by the employee for the purpose of paying for medical expenses not covered by the employer's health plan. The employee must be enrolled in a high deductible health plan that is HSA eligible in order to qualify for a HSA. Both employers and employees can contribute to a HSA. Unused funds are carried over to the following year.

HSA eligible health plans have deductible minimums and out-of-pocket limits that are indexed for cost-of-living adjustments annually. In 2005, these values were:

- A minimum annual deductible of $1,050 for single coverage and $2,100 for family coverage.
- An annual out-of-pocket limit that does not exceed $5,250 for single and $10,500 for family coverage.
- With the exception of preventive care, the annual deductible must be met before the plan benefits are paid.

Medical savings accounts (MSA): Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Most MSAs are combined with a high deductible or catastrophic health insurance plan. (The MEPS-IC survey stopped collection of information on MSAs in 2002 due to the development of HSAs.)

Self-insured plan: A plan offered by employers where the financial risk for the enrollee's medical claims is assumed partially or entirely by the organization offering the plan. Organizations with self-insured plans commonly purchase stop-loss coverage from a reinsurer who agrees to bear the risk (or stop the loss) for those expenses exceeding a predetermined dollar amount. Some self-insured employers contract with an insurance company or third party administrator for claims processing and other administrative services. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (including Conventional Indemnity, PPO, EPO, HMO, and POS) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.

Reinsurance: The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.

Stop-loss coverage: A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Third-party administrator (TPA): An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Fully insured plan: A plan where the employer contracts with another organization (health insurance company, carrier, HMO) to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

Underwriter: The company that issues an insurance policy and assumes the financial risk for covered individuals.

Insurance carrier: A corporation that engages in the business of selling insurance protection to the public, either directly or through employers, unions, etc.

Level of coverage

> **Single coverage:** Health insurance that covers the employee only. This is also known as employee-only coverage.
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> **Family coverage:** Health insurance that covers the employee and one or more members of his/her immediate family (spouse and/or children as defined by the plan). For the MEPS IC survey, "family coverage" is any coverage other than single and employee-plus-one. Some plans offer more than one rate for family coverage, depending on family size and composition. If more than one rate is offered, survey respondents are asked to report costs for a family of four.
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> **Employee-plus-one coverage:** Health insurance that covers the employee and one other family member at a LOWER PREMIUM LEVEL than family coverage. For the MEPS IC survey, if premiums are different for employee-plus-spouse and employee-plus-child coverage, the costs for employee-plus-child coverage are collected.

Premium: Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor.

Premium equivalent: For self-insured plans, this is the cost per covered enrollee, or the amount the organization would expect to pay in premiums if the plan were insured by someone else. The premium equivalent is equal to the per-capita amount of claims, administration, and stop-loss premiums for a self-insured plan.

Deductible: A fixed dollar amount during the benefit period: usually a year: that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.

Copayment: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received, regardless of the total charge for service. The insurer is responsible for the rest of the reimbursement. There may be separate copayments for different services. For example, an enrollee may pay a $10 copay for each doctor's office visit, $75 for each day in the hospital, and $5 for each prescription. Some plans require that a deductible first be met for some specific services before a copayment applies.

Coinsurance: A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges in excess of what the insurer determines to be “usual, customary and reasonable”. Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list. In addition to overall coinsurance rates, rates may also differ for different types of services.

Formulary: A formulary is a list of prescription drugs that are preferred by the health plan for use. A formulary may include brand-name and generic drugs.

Maximum out-of-pocket expense: The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum.

Maximum plan dollar limit: The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. Plans can have a yearly and/or a lifetime maximum dollar limit. The most typical of maximums is a lifetime amount of $1 million per individual.

Pre-existing condition limitation: Restricts coverage for medical or health conditions which exist prior to enrollment in a health plan. Pre-existing conditions may be excluded from coverage, or enrollees may have to wait a specified length of time before medical care related to the pre-existing condition is covered by the health plan.

II. Additional Terms That Appear in the MEPS-IC Tables

Establishment: A particular workplace or physical location where business is conducted or services or industrial operations are performed. Also known as a site. MEPS-IC data are collected at the establishment level whenever possible.

Firm: A business entity consisting of one or more establishments under common ownership or control. Also known as an enterprise. A firm represents the entire organization, including the company headquarters and all divisions, subsidiaries and branches. A firm may consist of a single-location establishment or multiple establishments. In the case of a single-location firm, the firm and establishment are identical. Firm size is the total number of employees for the entire firm as reported on the sample frame.

Industry categories: The primary business activity as reported by the respondent. Some industry categories are abbreviated in the tables (as shown in the list below). From 1996 to 1999, the industries were based on SIC (Standard Industrial Classification) codes. Beginning in 2000, the industries were converted to NAICS (the North American Industry Classification System). During this transition, even categories that retained the same name are not comparable due to the reclassification of specific businesses from one industry category to another. Making year-to-year comparisons of MEPS data by industries across the 1999: 2000 boundary is not recommended. For more information on NAICS, visit the Census Bureau's NAICS web site.

SIC industry categories used by MEPS IC for collection (1996-1999)	NAICS industry categories used by MEPS IC for collection (2000-current)	NAICS Sector
Agriculture (agric.)	Agriculture (agric.)	11
Fishing (fish.)	Fishing (fish.)	11
Forestry (forest.)	Forestry (forest.)	11
Mining	Mining	21
Manufacturing	Manufacturing	31,32,33
Construction	Construction	23
Retail trade	Retail trade	44,45
Wholesale trade	Wholesale trade	42
Transportation (transp.)	Transportation(transp.)	48,49
Utilities (util.)	Utilities(util.)	22
Communications (commu.)	Financial services(fin. svs.)	52,55
Finance (fin.)	Real estate (real est.)	53
Insurance (ins.)	Professional services	51,54,61,62
Real estate (real est.)	Other services	56, 71,82,81
Services		

Industry grouping: For data estimation and reporting purposes, groups of industry categories are constructed in the creation of MEPS-IC tables. Without grouping the industries, the cell sample sizes would be insufficient for producing estimates.

For the Table I series (National Estimates by Firm Size), the industry groups are:

NAICS industry groups used by MEPS IC in Table I series	NAICS Sector
Agriculture (agric.), Fishing (fish.), Forestry (forest.)	11
Mining and Manufacturing	21,31,32,33
Construction	23
Utilities (util.) and Transportation (transp.)	22,48,49,
Wholesale trade	42
Financial services (fin. svs.) and Real estate (real est.)	52,53,55,
Retail trade	44,45
Professional services	51,54,61,62
Other services	56,71,82,81

For the Table V series (State by Industry Groupings), the industry groups are:

NAICS industry groups used by MEPS IC in Table V series	NAICS Sector
Agriculture (agric.), Fishing (fish.), Forestry (forest.) and Construction	11,23
Mining and Manufacturing	21,31,32,33
Retail trade, other services	44,45, 56,71,82,81
Professional services	51,54,61,62
All other	22, 42,48,49,52, 53,55

Exclusive-provider plan: A plan in which the covered persons must to go to providers associated with the plan for all non-emergency care in order for costs to be covered.

Any-provider plan: A plan that allows covered persons to go to the providers of their choice with no cost incentives to use a particular subset of providers. Often referred to as a Conventional Indemnity plan.

Mixed-provider plan: A plan that allows covered persons to go to any provider but there is a cost incentive to use a particular subset of providers.

Managed care plan: Either a mixed provider or exclusive provider plan.

Low-wage employee: From 1996 through 1999, a low-wage employee was defined as an employee making $6.50 per hour or less and that rate was not adjusted for increasing wage levels. Beginning in 2000, the definition of a low-wage employee was redefined as those earning at or below the 25th percentile for all hourly wages in the United States based on data from the Bureau of Labor Statistics. Using this new criterion, the dollar amount used to define this category is adjusted each year based on the most recent wage data available so that the wage level will remain constant relative to overall wages from year-to-year. For 2000 through 2003, a low-wage employee was defined as someone who makes $9.50 per

hour or less; in 2004, it was raised to $10.00 per hour. Making comparisons of changes across the 1999: 2000 survey years regarding low-wage employees is not recommended due to the definition change.

Division (Census division): The States are grouped in the tables by the following Census divisions:

New England: Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	**West North Central:** Iowa Kansas Minnesota Missouri Nebraska North Dakota South Dakota	**West South Central:** Arkansas Louisiana Oklahoma Texas
Middle Atlantic: New Jersey New York Pennsylvania	**South Atlantic:** Delaware District of Columbia Florida Georgia Maryland North Carolina South Carolina Virginia West Virginia	**Mountain:** Arizona Colorado Idaho Montana Nevada New Mexico Utah Wyoming
East North Central: Illinois Indiana Michigan Ohio Wisconsin	**East South Central:** Alabama Kentucky Mississippi Tennessee	**Pacific:** Alaska California Hawaii Oregon Washington

Average wage quartiles: Four groups of private-sector establishments, each containing 25 percent of the total U.S. employment. Establishments in the lowest of the four quartiles (1st quartile) have lower average payrolls per employee (compensation excluding fringe benefits) than any establishment in the 2nd quartile. Establishments in the 2nd quartile have lower average payrolls than any establishment in the 3rd quartile, and establishments in the 4th (or highest) quartile have average payrolls greater than any establishment in the other three quartiles. (Table VIII series)

III. Other Health Insurance Terms of Relevance

ASO (administrative services only): An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health care plans.

Covered persons: An enrollee plus any dependents covered by a health insurance plan. The MEPS IC survey has no data on covered persons.

Group purchasing arrangement: Any of a wide array of arrangements in which two or more small employers purchase health insurance collectively, often through a common

intermediary who acts on their collective behalf. Such arrangements may go by many different names, including cooperatives, alliances, or business groups on health. They differ from one another along a number of dimensions, including governance, functions and status under federal and State laws. Some are set up or chartered by States while others are entirely private enterprises. Some centralize more of the purchasing functions than others, including functions such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks. Depending on their functions, they may be subject to different State and/or federal rules. For example, they may be regulated as Multiple Employer Welfare Arrangements (MEWAs).

Association health plans: This term is sometimes used loosely to refer to any health plan sponsored by an association. It also has a precise definition under the Health Insurance Portability and Accountability Act of 1996 that exempts from certain requirements insurers that sell insurance to small employers only through association health plans that meet the definition.

Multiple employer welfare arrangement (MEWA): MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a State-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers.

Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), although States generally also retain the right to regulate them, much the way States regulate insurance companies. They can be funded through tax-exempt trusts known as Voluntary Employees Beneficiary Associations (VEBAs) and they can and often do use these trusts to self-insure rather than to purchase insurance policies.

Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. These MEWAs are not considered to be health plans under ERISA. Instead, each participating employer's plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves. These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from State-licensed insurance companies or HMOs. They do not tend to self-insure.

Health Insurance Portability and Accountability Act (HIPAA): This federal law, enacted in 1996, protects health insurance coverage for workers and their families when they change jobs by limiting exclusions for pre-existing conditions, prohibiting discrimination against employees and dependents based on their health status, and guaranteeing renewability and availability of health coverage to certain employers and individuals.

Minimum premium plan (MPP): A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

Multi-employer health plan: Generally, an employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers. These plans are also known as Taft-Hartley plans or jointly-administered plans.

They are subject to federal but not State law (although States may regulate any insurance policies that they buy). They often self-insure.

Health care plans and system

- **Indemnity plan:** A type of medical plan that reimburses the patient and/or provider as expenses are incurred.
- **Conventional indemnity plan:** An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.
- **Preferred provider organization (PPO) plan:** An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
- **Exclusive provider organization (EPO) plan:** A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.
- **Health maintenance organization (HMO):** A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.
    - **Group model HMO:** An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.
    - **Staff model HMO:** A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.
    - **Network model HMO:** An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multi-specialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.
- **Individual practice association (IPA) HMO:** A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

- **Point-of-service (POS) plan:** A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

- **Physician-hospital organization (PHO):** Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

Managed care plans: Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include:

- Health maintenance organizations (HMOs),
- Preferred provider organizations (PPOs),
- Exclusive provider organizations (EPOs), and
- Point of service plans (POSs).

Managed care provisions: Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:

- **Preadmission certification:** An authorization for hospital admission given by a health care provider to a group member prior to their hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider's obligation to pay for services rendered.
- **Utilization review:** The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
- **Preadmission testing:** A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
- **Non-emergency weekend admission restriction:** A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions.
- **Second surgical opinion:** A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

Usual, customary, and reasonable (UCR) charges: Conventional indemnity plans operate based on usual, customary, and reasonable (UCR) charges. UCR charges mean that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.

Preferred ("in-network"/participating) provider: A medical provider (doctor, hospital, pharmacy) who is a member of a health plan's network. Enrollees generally pay lower or no copayment for services from a preferred provider.